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ABSTRACT

This paper suggests that in an increasingly multicultural world, cultural competence requires that racism, power, oppression, and privilege be fully acknowledged and addressed to maximize the effectiveness of clinical interventions. Psychotherapists must learn to appropriately address racial or cultural differences in the therapy room. In order to do the necessary work, racism, sexism, classism, heterosexism, and other forms of oppression must be viewed as part of the cycle of perpetuated violence and trauma. The "Diagnostic and Statistical Manual of Mental Disorders," fourth edition, provides a means for taking cultural perspectives into account in therapy; thus, in order to make an accurate diagnosis and maximize clinical outcomes, the cultural context of clients must be understood and respected. Examples are given of consultations in which asking culturally appropriate questions led to positive results for clients that could not have occurred otherwise. Cultural competence must be viewed as an ongoing, dynamic process to be proactively addressed throughout one's practice. Rather than learning a static list of cultural characteristics, the therapist should take a stance of being respectfully naive and curious, provide a safe environment for cultural stories to unfold, then reflect insights nonjudgmentally. Psychotherapists must receive more specific training on cultural competence. Six important components of training in cultural competence are listed. (EMK)

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Developing Cultural Proficiency in Clinical Practice

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Within the next several years, ethnic communities will be "majority" in California. In order to keep in step with the mandates of ethical practice, psychologists and family therapists must become at least culturally competent. To be minimally competent, practitioners must: have acceptance and respect for differences; expand their own cultural knowledge; be aware of the dynamics that differences create; adapt service models and skills; seek consultation from the cultural community of the client and engage in continuous self-assessment during the therapeutic process. If these processes are kept in sharp focus in practitioners' clinical view, they can better facilitate healing and well being in their clients. When culture and differences are held in high regard, there will be continuous efforts to expand knowledge and ongoing advocacy for cultural competence at all service levels (Cross, 1989). With increasing need, psychotherapists who become more culturally proficient along multiple dimensions will be in higher demand as practitioners and consultants. As a consequence of ongoing cultural competence training, challenges or practice "crises" will become clinical opportunities.

While generally used, the concept of cultural competence has become more complex and difficult to actually put into practice (Hardy, 1997). In public mental health, cultural competence standards have been developed followed by criteria to show program and individual compliance (California State Department of Mental Health, 1997). Within these standards there must be observable changes in behaviors, skill attainment and attitudes in order for a therapist to be judged competent to work with cultural others.

Cultural competence also requires that racism, power, oppression and privilege be fully acknowledged and addressed so as to maximize the effectiveness of clinical interventions. This means that the therapeutic relationship itself may be used as a microcosm of power inequities. In working with a client of different ethnicity or background, for example, there might be an early opportunity to remark "I am aware that you and I are of different cultural backgrounds. A dialogue about this might arise during the course of our work together which would be welcomed." This creates openings to talk about how the therapist might be perceived, consciously or unconsciously as an oppressive figure, sit in "the chair of greater power" or control resources such as receiving payment, acknowledging when the session is over, reporting suspected abuse, etc. Addressing these issues in the therapy room could very well provide awareness or insight to the client about parallels in their lives and presenting problems. For example, when an African American man was referred by his company for psychotherapy for job stress, an appropriate opportunity arose for us to discuss our being different. He questioned how I could understand and empathize since I am Asian American and had perhaps not experienced similar pressures. Exploring these issues led to discussions about how he had been passed over for promotions, feelings that he had to try even harder than others to achieve, and, how experiences of discrimination affected his relationships in society. Working with his feelings towards me led to powerful awareness of inequities in his life and how to effectively address them. He also talked about pent up anger towards those who represented "the favored others" which included me. In time he understood that his being externally proactive would be far more effective than passive resignation. He made changes in his work, and began his own business which had been one of his lifelong dreams. His understandable anger and mounting rage became transformed into pursuing his personal passions in more effective ways.

While being highly acknowledged as having deleterious effects in society, the impact of power inequities and manifestations of oppression on mental health or illness is rarely taught in schools (Pinderhughes, 1989). Similar manifestations as they arise in the therapeutic relationship are only now being acknowledged in some areas. DSM-IV (American Psychiatric Association, 1994) has often been touted as a great advancement in having culturally expressed syndromes and cultural prevalence of pathologies. However, one might ask, why racism or oppression are not listed as a clinical problems? How often are oppression, discrimination or racism been listed on axis IV as psychological stressors? In response, one longstanding therapist commented: "We accept that racism is everywhere in our society so we don't have to list it. It's a given." Another remarked: "If we list them, we might further jeopardize our client or we might not be paid for our work." With these views, might therapists actually be colluding with the cycle of oppression?

How comfortable are therapists in appropriately addressing racial or cultural differences in the therapy room? When dialogue is opened, is it a welcome offering or point to be made only then to be passed over? During a consultation with a program serving clients mandated by the courts as a part of diversion, I asked the self-identified primarily white, Euroamerican therapists if they addressed racial differences

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with their predominantly Black, Latino and some Asian referrals. One therapist said she always made it a practice to raise the issue, something like "You're Latino and I am white. I wonder if this might create difficulties in our work together?". As one might imagine, few of the court-ordered clients responded affirmatively verbally but their rates of dropping out of counseling was high. In other words, given the inherent manifestations of power dynamics, appropriate framing of such inquiries into differences is essential.

In order to do the necessary work racism, sexism, classism, heterosexism and other forms of oppression must be viewed as a part of the cycle of perpetuated violence and trauma. As psychotherapists we can address these forms of violence and trauma by examining ourselves, understanding the historical construction of race and resulting racism, and ways to effectively address oppression in therapy. The risk of not doing so would be to replicate some of the deleterious effects of racism and oppression in society. Research and literature underscore how racism contributes to negative health and mental health outcomes among ethnic groups. In this nation, violence has become the number one health issue (Kreiger and Sidney, 1996). Acts of racism are perpetuations of a cycle violence. Thus, psychotherapists can play a major role in deconstructing race, racism and related social politics so that we can contribute to increasingly healthy, reconstructive, transformative interactions.

Only recently in the DSM-IV (APA, 1994) is there noticeable recognition of culture in making a cultural formulation and taking cultural perspectives into account in assessment. The DSM IV outlines five important areas in making a cultural formulation: 1) the cultural identity of the individual and family; 2) cultural explanations given for the illness; 3) cultural factors related to the psychosocial environment and levels of functioning; 4) cultural elements of the relationship between the individual and clinician and 5) overall assessment for diagnosis and care. Thus, in order to make an accurate diagnosis and maximize clinical outcomes, the cultural context of clients must be understood and respected. Use of the cultural formulation is useful for all clients and is absolutely essential for many (Mock, 1995). A recently immigrated Latina was held for psychiatric observation appearing disoriented, uncommunicative and possibly delusional, speaking to her father who was known to be deceased. Initially being provisionally diagnosed as psychotic and given psychotropic medication, a mental health counselor who spoke her native Spanish provided a more thorough assessment. This woman related little to the male police officers who had detained her, fearing that her legal status was in question. When asked about speaking to her father, she conveyed deriving comfort from praying to his spirit after his death. Upon closer careful examination, there were indications that the woman had been the victim of a recent assault. Rather than being psychotic or needing medication, the most relevant diagnosis was post traumatic stress disorder. She greatly improved after several outpatient sessions without medications.

In another case, a Navajo man was self-referred for treatment. What was perceived as depression was caused, he believed, by spiritual unrest. He had several experiences of discrimination and loss. Our cultural differences led to critical discussions of trust and previous interactions with health care systems. In addition to culturally-syntonic rituals and grieving, he was linked up to the Community of United Indian Nations where other Navajos assisted him in employment opportunities and support. In this abbreviated example, the cultural formulation not only provided culturally appropriate nosology but sensitive treatment planning and interventions.

Cultural competence must be viewed as an ongoing, dynamic not static process to be proactively addressed throughout one's practice. Rather than learning a static list of cultural characteristics, perhaps the stance of the therapist in being respectfully naive and curious (Dyche and Zoyas, 1995) may be more effective. In order to see the view of others more clearly we need to hold "reflections". That is, clients give us insights to their lives which we may not fully understand or relate to. Like an effective ethnographer, we should withhold critical judgement providing a safe environment for cultural stories to unfold then reflect observations and awareness to clients.

As cross cultural therapists perhaps we are not the experts but the families we work with are the owners of their deeply personal cultural stories which we might be privileged to share (Mock, 1998; Breunlin, Schwartz and MacKune-Karrer, 1992). When we explore our clients' cultures and cultural narratives, we become more acutely aware of cultures-within-cultures, and stories-within-stories. These "multilayered realities" are often revealed in family sessions. A Japanese family sought treatment for the "acting out" of their young adult son. During the process of completing a multigenerational cultural genogram, there was a temporary impasse that was reached. Upon reflecting how the family felt "stuck" and turning to the father for leadership, he painfully described how he had been interned during World War II and had carried the family shame from this experience. As is sometimes the case for other Asian families this provided an opportunity for the telling of historical stories, how these stories live in the present, and ways in which they may underlie relationships (Wong and Mock, 1997). The son began to discuss his emotional distance from his father and interpretation of what he perceived as being "closed down" to lack of caring. His remarks of hopes for his and his family's future led to openings for more healthy dialogue and interactions.

One of the important ethical standards of the profession is for psychotherapists to operate within their scope of practice (American Psychological Association,

1981; Board of Behavioral Science, 1996). However, most psychotherapists have not received specific trainings on working with multicultural communities. When they have had courses or workshops content is often limited leading to a false sense of "knowing the other". Therefore a clear challenge is created: in order to work with ethnic and diverse clients, therapists must receive more specific training on cultural competence or risk practicing unethically "beyond their scope" of ability (Hall, 1997). More specifically, psychotherapists must acquire appropriate cultural knowledge, skills and attitudes in a dynamic, ongoing process. The option to refer only to those of similar background to the client is a limited resource, and a luxury few communities can afford. In multicultural, multiethnic localities, mental health systems often attempt to match therapists and clients of similar backgrounds. One relatively successful effort is a private practice, the Multicultural Clinical Center (MCC), in northern Virginia, Washington, D.C. and Maryland. Founded by a Peruvian-African clinical social worker, the MCC is staffed by part-time bilingual clinicians who are licensed psychiatrists, psychologists and social workers. Clients are of Latino, Asian, Southeast Asian, European, African and other backgrounds. Now in existence for over 10 years, the MCC has served clients who are diverse not only in culture but educational level, socio-economic status, and diagnostic presentation. The MCC model works in the metropolitan Washington, D.C. area, but it may not work well in localities that do not have multicultural, bi-lingual, multidiscipline professionals and clients (Fong, 1998).

What constitutes training in and personal pursuits of cultural competence so that clients can be approached with some degree of cultural proficiency? There are several components, including:

• First, acknowledgement that each of us are limited by our own world view, that we are shaped by our own family background, personal stories, professional training and experience. As we examine our own world view, we become more aware of factors that contribute to our countertransference reactions to culturally different others.

• Second, recognize that maintaining cultural competence in the profession requires ongoing consultation and continuous learning, such as being certified (i.e. declared "competent") in specific clinical specialties.

• Third, respectfully acknowledge that developing competency is an ongoing, dynamic process that does not exist automatically because the therapist himself or herself belongs to an ethnic community. Formal cultural competence training and supervision must be essential ingredients so that our clinical judgments are focused, appropriately defined, ethnically sensitive, and health promoting.

• Fourth, develop a stance of "informed naivete" and humility in working with cultural others. Oftentimes an attitude of respectfully not knowing everything can lead to a better "fit" or openness to differing perspectives. Stereotypes can work to hinder the therapeutic relationship.

• Fifth, at a conceptual level, cultural competence training must also use the rich resources found in the professional literature of related disciplines, including anthropology, sociology, political science, and history incorporating different American ethnic communities. Racism, for example, is embedded in all of these arenas as well as in the psyche of many ethnic minorities.

• Sixth, the movement towards cultural competence in psychology (and thus in mental health) must go forward by: a) translating conceptual ideas into daily practice; b) defining clear, achievable goals and action plans for training practitioners and educators who may be members of larger systems; c) setting standards and criteria for certification towards a "proficiency in cultural competency"; d) developing additional principals of ethical and professional cultural competency practice; and e) incorporating cultural competence at all levels of system change so that progress does not happen in isolation. Progressive change must be institutionalized and sustained.

As we hold ourselves accountable to striving towards and maintaining cultural competence, we also stretch ourselves to better understand ethnic and other diverse clients. At the same time, we will develop new dimensions in relevant psychological theory and practice contributing to a better world.

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